114.6 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.6 CMR 12.00: SERVICES ELIGIBLE FOR PAYMENT FROM THE UNCOMPENSATED CARE TRUST FUND

Sections

12.01: General Provisions

(1) Scope, Purpose, and Effective Date. 114.6 CMR 12.00 specifies the criteria effective January 1, 2005 for determining the services for which hospitals and community health centers may be paid from the Uncompensated Care Trust Fund.

(2) Authority. 114.6 CMR 12.00 is adopted pursuant to M.G.L. c. 118G.

12.02: Definitions

Meaning of Terms. As used in 114.6 CMR 12.00, unless the context otherwise requires, the following terms shall have the following meanings. All defined terms in 114.6 CMR 12.00 are capitalized.

Allowable Medical Expenses. Family medical bills from any health care provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Unpaid bills for which the patient is still responsible, incurred prior to or after the date of a MassHealth application, may be used. Paid bills incurred after the date of the MassHealth application may also be included in Allowable Medical Expenses.

Ancillary Services. Non-routine services for which charges are customarily made in addition to routine charges, that include but are not limited to laboratory, diagnostic and therapeutic radiology, surgical services, and physical, occupational or speech-language therapy. Generally ancillary services are billed as separate items when the patient receives these services.

Application. The electronic application form issued by the Division pursuant to 114.6 CMR 10.00.

Bad Debt. An account receivable based on services furnished to any patient that: (a) is regarded as uncollectible, following reasonable collection efforts, pursuant to 114.6 CMR 12.05 and the Provider's established Credit and Collection policy; (b) is charged as a credit loss; (c) is not the obligation of any federal or state governmental unit; and (d) is not a Low Income Patient as defined in 114.6 CMR 12.03.

Caretaker Relative. An adult that is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

CenterCare Program. An ambulatory managed care program that offers primary and preventive health care services to low-income, uninsured adult patients of independently licensed Community Health Centers, administered by the Department of Public Health, pursuant to M.G.L., c.111, §24H.

Charge. The uniform price for a specific service charged by a Provider.

Children's Medical Security Plan (CMSP). A program of primary and preventive pediatric health care services for eligible children, from birth to age 18, administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E, § 10F.

Collection Action. Any activity by which a Provider or designated agent requests payment for services from a patient, a patient's guarantor, or a third party responsible for payment. Collection Actions include activities such as pre-admission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commissioner. The Commissioner of the Division of Health Care Finance & Policy or designee.

CommonHealth. A MassHealth program for disabled adults and disabled children administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E.

Community Health Center. A clinic that (a) provides comprehensive ambulatory services and is licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c.111, §51, (b) meets the qualifications as a Community Health Center for certification (or provisional certification) by the Office of Medicaid and enters into a provider agreement pursuant to 130 CMR 405.000, (c) operates in conformance with the requirements of 42 U.S.C. §254c, and (d) files cost reports as requested by the Division.

Credit and Collection Policy. A statement, in compliance with 114.6 CMR 12.04, of a Hospital's general policy and the principles that guide its billing and collection practices and procedures, as approved by its governing board.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Eligible Services. Services for which Providers may be paid from the Uncompensated Care Trust Fund. Eligible Services include Eligible Services to Low Income Patients that meet the criteria in 114.6 CMR 12.03; Emergency Bad Debt services that meet the criteria in 114.6 CMR 12.04; and Medical Hardship services that meet the criteria in 114.6 CMR 12.05.

Emergency Aid to the Elderly, Disabled and Children (EAEDC). A program of governmental benefits under M.G.L. c. 117A.

Emergency Services. Services needed to evaluate or stabilize a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a patient, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

EMTALA. The federal Emergency Medical Treatment and Active Labor Act under 42 U.S.C. § 1395(dd).

Family. Persons that live together, and consists of: (1) a child or children under age 19, any of their children, and their parents; (2) siblings under age 19 and any of their children that live together even if no adult parent or Caretaker Relative is living in the home; or (3) a child or children under age 19, any of their children, and their Caretaker Relative when no parent is living in the home. A Caretaker Relative may choose whether or not to be part of the Family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is: a) pregnant; or be) a parent. A child that is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children that live with them.

Family Income. Gross earned and unearned income as defined in 130 CMR 506.003.

Federal Poverty Income Guidelines. Income standards issued annually in the Federal Register.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Free Care. Unpaid Hospital or Community Health Center charges for services that are eligible for payment from the Uncompensated Care Pool pursuant to 114.6 CMR 10.00.

Governmental Unit. The Commonwealth, and any department, agency, board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Income. The total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Guarantor. A person or group of persons that assumes the responsibility of payment for all or part of a Provider's charge for services.

Health Insurance Plan. The Medicare program, the MassHealth program, or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, as defined in M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I.

Healthy Start. A health care program for pregnant women and infants administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E, § 10E.

Hospital. An acute hospital licensed under M.G.L. c. 111, §51 and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.

Hospital Licensed Health Center. A facility that is not physically attached to the Hospital, or located on or proximate to the Hospital campus, that: (1) operates under the Hospital's license; (2) meets MassHealth requirements for reimbursement as a hospital licensed health center under 130 CMR 410.413; (3) is approved by and enrolled with the MassHealth Enrollment Unit as a hospital licensed health center; (4) possesses a

distinct hospital licensed health center MassHealth provider number; (5) has CMS provider-based status in accordance with 42 CFR 413.65; and (6) provides services solely on an outpatient basis.

Hospital Services. Services listed on an acute hospital's license by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; and home health services, or separately licensed services, including residential treatment programs and ambulance services.

MassHealth. The medical assistance program administered by the Executive Office of Health and Human Services Office of Medicaid pursuant to M.G.L. c. 118E and in accordance with Titles XIX and XXI of the Federal Social Security Act, and a § 1115 Demonstration Waiver. .

MassHealth Application. A form prescribed by the Office of Medicaid to be completed by the Applicant or an Eligibility Representative, and submitted to the Office of Medicaid as a request for MassHealth benefits. It is either the Medical Benefits Request (MBR) or the common intake form designated by the Executive Office of Health and Human Services, or any other form designated by the Office of Medicaid.

Medically Necessary Service. A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include:
non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations and consultations; court testimony; research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and the provision of whole blood; except the administrative and processing costs associated with the provision of blood and its derivatives.

Medicare Program. The medical insurance program established by Title XVIII of the Federal Social Security Act.

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c. 118G, s.18.

Primary Care. Primary care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants, for purposes of prevention, diagnosis, or treatment of acute or chronic disease or injury, but excludes **Ancillary Services** and maternity care services.

Provider. A Hospital or Community Health Center that provides Eligible Services.

Resident. A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

REVS System. The MassHealth Recipient Eligibility Verification System of the Office of Medicaid.

Uninsured Patient. A patient that does not have a policy of health insurance or is not a member of a health insurance or benefit program. A patient that has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.

Urgent Care. Medically necessary services provided in a hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function, or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life-threatening and do not pose a high risk of serious damage to an individual's health.

12.03: Eligible Services To Low Income Patients.

(1) Providers may submit claims for Eligible Services that are:
(a) Permissible Services as defined in 114.6 CMR 12.03(2); and
(b) provided to a Low Income Patient as defined in 114.6 CMR 12.03(3);
(c) meet the billing criteria in 114.6 CMR 12.03(5).

(2) Permissible Services.
(a) Providers may submit claims only for services that are Medically Necessary.
(b) Site of Service
1. Hospitals. Effective January 1, 2005, a Hospital may submit claims only for Critical Access Services. Critical access services are medically necessary Hospital Services, including inpatient services, certain outpatient services, and services provided in a hospital-licensed facility located off the hospital campus that is a Hospital Licensed Health Center, a school-based health center, or other satellite location. Critical access services do not include on-campus outpatient clinic visits for non-emergent or non-urgent Primary Care unless
a. there is no Community or Hospital Licensed Health Center providing both adult and pediatric Primary Care within 5 miles driving distance of the hospital campus as determined by the Division; or
b. the patient's medical condition is so severe or complex that his/her primary care cannot be adequately provided in a community setting. This determination shall be made by the treating clinician, and must be a reasonable clinical judgment based on prevailing standards of care. The reasons for such a determination must be documented in the patient's record.
Effective January 1, 2005, each claim submitted by a Hospital must identify the specific location at which the service was provided.
2. Community Health Centers. A Community Health Center may submit claims for Ancillary Services only if the services are provided on site.

(3) Low Income Patient. A Low Income Patient must be a Resident of the Commonwealth and determined to be a Low Income Patient pursuant to 114.6 CMR 12.03(4). A Low Income Patient must meet the criteria specified below.
(a) Income Criteria to Submit Claim for all Eligible Services. Providers may submit claims for all Eligible Services provided to an individual that:

1. documents Family Income equal to or less than 200% of the Federal Poverty Income Guidelines; or
2. is enrolled in MassHealth; or
3. receives benefits under the CenterCare program; or
4. participates in the Children's Medical Security Plan or Healthy Start and whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines; or
5. receives benefits under the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program and has applied for MassHealth.

(b) Income Criteria to Submit Partial Claim for Eligible Services. Providers may submit claims for a portion of Eligible Services provided to an individual that

1. documents Family Income from 201% to 400% of the Federal Poverty Income Guidelines; or
2. participates in Children's Medical Security Plan and whose Family Income is from 201% to 400% of the Federal Poverty Income Guidelines; or
3. participates in Healthy Start whose Family Income is from 201% to 225% of the Federal Poverty Income Guidelines.

(4) Low Income Patient Determination.

(a) Application for MassHealth. In order to be determined a Low Income Patient, an individual must complete a MassHealth Application and submit all documentation required under 130 CMR 502.000. Applications will be processed by Office of Medicaid MA-21 system. The Office of Medicaid will notify the individual whether he or she has been determined:

1. eligible for MassHealth;
2. ineligible for MassHealth but determined to be a Low Income Patient; or
3. ineligible for MassHealth and determined not to be a Low Income Patient.

(b) Exceptions.

1. Transition Period for Low Income Patient Determination. There will be a Transition Period for Providers to convert to the MA-21 system for Low Income Patient Determination. The Division will identify and schedule Providers for conversion to the MA-21 system. Providers will continue to process and submit electronic Applications until notified by the Division that they must use the MA-21 system for Low Income Patient determinations. During the first 60 days following such notice, a Provider may use either the MA-21 system or the electronic Application process. After 60 days, the Provider must use the MA-21 system.
2. Providers will continue to process Applications for individuals for whom MA-21 does not process MassHealth Applications. Unless otherwise specified by 114.6 CMR 12.00, Providers will use the standards and procedures in 114.6 CMR 10.00 to process such Applications. Providers will process Applications for the following:
    a. Applicants filing during the Transition Period; and
    b. Applicants who are 65 or over.

(c) Verification of Income.

1. Verification of gross monthly earned income is mandatory and shall include, but not be limited to, the following:
    a. two recent pay stubs;
    b. a signed statement from the employer; or

c. the most recent U.S. tax return.

2. Verification of gross monthly unearned income is mandatory and shall include, but not be limited to, the following:

a. a copy of a recent check or pay stub showing gross income from the source;

b. a statement from the income source, where matching is not available;

c. the most recent U.S. Tax Return.

3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

4. Minors receiving confidential services under M.G.L. c. 112, § 12F may apply to be determined a Low Income Patient using their own income information. If a minor is determined to be a Low Income Patient, the Provider may submit claims for confidential medically necessary services provided under M.G.L. c. 112, § 12F when no other source of funding is available to pay for the services confidentially. Providers may submit claims based on a minor patient's own income information for other medically necessary services only where such treatment is confidential under state or federal law and where no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process.

(d) Grievance Process. An individual may request a review of the determination that he or she is not a Low Income Patient.

1. Determination by MA-21. The Division will conduct a review using the following process.

a. In order to request a review, the individual must send a written complaint to the Division, with supporting income documentation. The Division may request additional information.

b. When the Division has received all necessary information, it will issue a written decision to the individual and to the Provider within 30 days of the receipt of all necessary information. The Division's decision will contain a brief explanation of the reasons for the decision.

2. Determination by Provider. The Division will conduct a review using the following process.

a. In order to request a review, the individual must send a written complaint to the Division, with supporting income documentation. The Division may request additional information from the individual.

b. The Division will send a copy of the complaint to the Provider and request a response. The Division may request additional information from the Provider.

c. The Provider is required to file a written response within 30 days.

d. When the Division has received all necessary information, it will review the complaint and the Provider's response. The Division will issue a written decision to the individual and to the Provider within 30 days of the receipt of all necessary information. The Division's decision will contain a brief explanation of the reasons for the decision.

(e) Matching Information. The Office of Medicaid initiates matches with other agencies and information sources when a MassHealth application is received. These agencies and

information sources may include, but are not limited to, the following: the Department of Employment and Training, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance, and health insurance carriers.

(5) Eligibility Period.

(a) For individuals determined to be Low Income Patients during the period from October 1, 2004 to September 30, 2005, Providers may submit claims for Permissible Services for the period beginning six months prior to (1) the date that MassHealth eligibility begins as determined by the Office of Medicaid, or (2) if the Provider is processing the application pursuant to 114.6 CMR 12.03(4)(b), the date the Provider determines that the applicant is a Low Income Patient.

(b) The determination that an individual is a Low Income Patient will be effective for one year from the date of determination, unless over the course of that year the patient's Family Income or insurance status changes to such an extent that the patient becomes ineligible.

(c) If an individual has been determined eligible for Free Care pursuant to the provisions of 114.6 CMR 10.00 during the period from October 1, 2003 to September 30, 2004, the patient will be considered a Low Income Patient for a period of one year after the date of determination.

(6) Claims for Eligible Services.

(a) Claims for Eligible Services to Low Income Patients determined pursuant to 114.6 CMR 12.03(3)(a) (Income up to 200% FPL)

1. Uninsured Low Income Patient. A Provider may submit a claim for all Eligible Services that are provided to uninsured Low Income Patients.

2. MassHealth enrolled/Low Income Patient. A Provider may submit a claim only for Eligible Services not covered by MassHealth. Providers must check the REVS system prior to submitting a claim for Eligible Services to Low Income Patients to determine if the service can be billed to MassHealth.

3. Insured Low Income Patient. An insured patient may file an application for MassHealth and Low Income Patient Determination to cover his or her financial liability after any insurance program or policy has paid the amount for which it is responsible. An individual must submit a copy of the insurance program or policy's Explanation of Benefits (EOB) with the application. If this is not available, the applicant may submit a copy of the bill from the Provider indicating the balance due from the patient, or a copy of the patient's insurance card or policy.

4. CMSP. A Provider may submit a claim for Eligible Services not covered by CMSP only if the individual enrolled presents a CMSP card that shows income up to 400% of the FPL.

(b) Co-payments and Deductibles.

1. Co-payments and deductibles for Low Income Patients including patients enrolled in MassHealth, Healthy Start, CMSP, or CenterCare are not Eligible Services.

2. Co-payments and deductibles for Low Income Patients covered by other insurance programs are Eligible Services to the extent that such charges are related to Permissible Services not covered by the patient's insurance program.

(c) Claims for Eligible Services to Low Income Patients determined pursuant to

114.6 CMR 12.03(3)(b) (Income between 201% and 400% FPL).

1. Annual Deductible. The Annual Deductible for Partial Payment equals 40% of the difference between the applicant's Family Income and 200% of the Federal Poverty Income Guidelines. The patient is responsible for payment for all services provided up to this Deductible amount.

a. Annual deductible per family. The total amount of an individual's co-payments is capped in any given year by the Annual Deductible. There is only one Partial Payment Deductible per Family per approval period.

b. Deductible Tracking. The annual Deductible is applied to all Eligible Services provided to a Low Income Patient or family member during the Eligibility Period. Each family member must be determined a Low Income Patient in order for their expenses for Eligible Services to be applied to the Deductible. The Provider must track the patient's Eligible Service expenses until the patient meets the Deductible. If more than one Family member is determined to be a Low Income Patient, or if the patient or Family members are determined to be Low Income Patients by more than one Provider, it is the patient's responsibility to track the Deductible and provide documentation to the Provider that the Deductible has been reached.

1. Hospitals. The patient must incur expenses for Eligible Services in excess of the Annual Deductible before the Provider can submit a claim for Eligible Services. Once the patient has met the Deductible, the Provider may submit a claim for the remaining balance of Eligible Service expenses. The Hospital may require a deposit and/or a payment plan in accordance with 114.6 CMR 12.08.

2. Community Health Centers. A Low Income Patient must pay a percentage of the bill based on a sliding fee scale until the patient meets the Deductible. Once the patient meets the Deductible, the Provider may submit a claim for the remaining balance of each bill and for all additional services rendered during the Eligibility Period.

The sliding fee scale appears below:

Income as a Percentage of Federal Poverty Income Guidelines	Percentage of Bill Paid by Patient
201% to 250%	20%
251% to 300%	40%
301% to 350%	60%
351% to 400%	80%

(d) Motor Vehicle Accidents. A Provider may submit a claim for a Low Income Patient injured in a motor vehicle accident only if (1) it has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy and (2) where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. If the Provider receives payment from the insurer, the Provider must offset the income from its claim for Eligible Services.

12.04: Emergency Bad Debt Services

(1) General. A Hospital may submit a claim for emergency bad debt for Hospital Services to an uninsured patient under the following conditions:

(a) The services were provided to an individual uninsured for the services provided and not a Low Income Patient. The Provider may not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; and

(b) The Hospital provided Emergency Services as defined in 114.6 CMR 12.02 to the patient. A Hospital may submit a claim for all Hospital Service charges resulting from the emergency visit, including any ancillary services, and any charges for an inpatient admission or observation stay; and

(c) The responsible physician determined that the patient required Emergency Services defined in 114.6 CMR 12.02. A Hospital may submit a claim for Emergency Services, but not for other services provided to patients determined not to require Emergency Services. If a Hospital cannot distinguish charges for screening services from charges for other Eligible Services , the Hospital may submit a claim equal to the amount paid by MassHealth for emergency screening services; and

(d) The Hospital undertook the required Collection Action as defined in 114.6 CMR 12.04(2) for the account; and

(e) The bill remains unpaid after a period of 120 days.

(2) Required Collection Action

(a) Collecting Patient Information.

1. Inpatient Services. A Hospital shall identify the department responsible for obtaining the information from the patient, and make reasonable efforts to obtain the financial information necessary to determine responsibility for payment of the Hospital bill from the patient or Guarantor. If the patient or Guarantor is unable to provide the information needed, and the patient consents, a Hospital shall make reasonable efforts to contact the relatives, friends and Guarantor and the patient for additional information while the patient is in the Hospital. If a Hospital has not obtained sufficient patient financial information to assess the ability of the patient or the patient Guarantor to pay for services prior to the date of discharge, the Hospital shall make reasonable efforts to obtain the necessary information at the time of the patient's discharge.

2. Emergency Room and Outpatient Services. A Hospital shall make reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or Guarantor.

(b) Verification of Patient-Supplied Information.

1. Inpatient. A Hospital shall make reasonable efforts to verify the patient-supplied information prior to the patient discharge. The verification may occur at any time during the provision of services, at the time of the patient discharge or during the collection process.

2. Outpatient. A Provider shall make reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process.

(c) Reasonable Collection Efforts.

1. The Hospital must make the same effort to collect accounts for Emergency Care for Uninsured Patients as it does to collect accounts from any other patient classifications.

2. The minimum requirements before writing off an account to the Pool include:

a. an initial bill to the party responsible for the patient's personal financial obligations,
b. subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation,
c. documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable,"
d. sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable."
e. documentation of continuous Collection Action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous Collection Action, the Division may use a gap in Collection Action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether a Provider has made a reasonable effort to meet the standard.

3. If after reasonable attempts to collect a bill, the debt for Emergency Services for an Uninsured Patient remains unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the Pool.
4. The patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

(d) DOR Intercept. The Division will initiate a match with the Department of Revenue for individuals for whom a Hospital has submitted a claim for Emergency Bad Debt services. The Division may request that the Department intercept payments to the individual up to an amount equal to: (1) charges for Emergency Bad Debt services provided to the individual, times (2) the Provider's Cost to Charge Ratio calculated pursuant to 114.6 CMR 11.00, and (3) an adjustment to account for the hospitals' estimated shortfall adjustment, if any.

12.05: Medical Hardship

(1) General. An applicant at any income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted the family's income and resources that he or she is unable to pay for Eligible Services.

(2) Eligibility. In order to qualify for Medical Hardship
(a) the applicant must be a Massachusetts Resident; and
(b) the applicant's Allowable Medical Expenses must exceed 30 percent of his or her Family Income; and
(c) the applicant's available assets must be insufficient to cover the cost of Allowable Medical Expenses that exceed 30% of the Family Income.

(3) Eligibility Process.
(a) Providers must process Medical Hardship applications.
(b) Providers must use the Medical Hardship supplement as provided by the Division to determine the Allowable Medical Expenses and available assets to be used in calculating eligibility for Medical Hardship. Patients applying for Medical Hardship must complete

both forms and provide the required supporting documentation in order to be eligible for Medical Hardship assistance.

(c) Notification of Determination.

1. Medical Hardship approval letters must: explain that the person is eligible for Medical Hardship for all Medically Necessary Services, include the dates of eligibility; include the amount of the patient's Medical Hardship contribution; inform the patient of any required deposit for non-emergency services; include information about written payment plans pursuant to 114.6 CMR 12.08(f) explain how to reapply at the end of the eligibility period; list the services that do not qualify as Eligible Services; include the name and number of a contact person for more information; explain how to file a grievance with the Division; and include the signature of an authorized person.

2. Medical Hardship denial letters must: explain why the patient is not eligible for Medical Hardship; include the name and number of a contact person for more information; explain how to file a grievance with the Division; and include the signature of an authorized person.

(4) Expense Determination

(a) Expense Qualification. The patient's total Allowable Medical Expenses must be greater than 30% of the Family Income. Allowable Medical Expenses are the total of family medical bills that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Paid bills and unpaid bills for which the patient is still responsible and for which the Provider may not bill the Pool, may be included.

(b) Resource Qualification. The patient's Excess Medical Expenses must be greater than Available Assets.

1. Excess Medical Expenses are the amount by which Allowable Medical Expense exceed 30% of the Family Income.

2. Available assets do not include the primary residence, the first motor vehicle, and a resource exclusion of the first $4,000 of other assets for an individual, or $6,000 for a Family of two, and $1,500 for each additional Family member.

(5) Applicant Contribution. The applicant's required contribution is the sum of 30% of Family Income and Available Assets. There is one Medical Hardship contribution per Family per eligibility period. The applicant will remain responsible for all Allowable Medical Expenses up to this Medical Hardship contribution.

(6) Claims. Providers may submit claims for Medical Hardship Services as follows:

1. determine the amount of Allowable Medical expenses billed by other Providers during the Eligibility Period.

2. If the Medical Hardship contribution exceeds the Allowable Medical Expenses billed by other Providers, the Provider will then apply its own Allowable Medical Expenses to the Medical Hardship contribution. The patient must pay that portion of the bill that the Provider applies to the Medical Hardship contribution.

3. The Provider may submit a claim for any balance for Eligible Medical Expenses above the patient's Medical Hardship contribution.

12.06: Diversion Fines

(1) Penalties for Diversion of Low Income Patients.

(a) A diversion is subject to a penalty if:

1. the Division finds that a Low Income Patient was transferred from one Hospital to another Hospital without the consent of the receiving Hospital; and
2. the transfer was in violation of EMTALA.

(b) For purposes of this section, a patient is considered Low Income if

1, the transferring Hospital knows the individual has been determined to be a Low Income Patient; or

2. the individual is subsequently determined to be a Low Income Patient at the time of the transfer.

(c) Penalties. The Division may assess a penalty, not to exceed $10,000, for each improper diversion of a Low Income Patient. Any amount collected pursuant to 114.6 CMR 12.00 shall be deposited into the Uncompensated Care Trust Fund.

(2) Hospitals must maintain records sufficient to document consent for transfers of Low Income Patients to other Hospitals and must make such records available to the Division upon request.

(3) The Division will review complaints of improper diversion of Low Income Patients and may initiate an investigation based on such complaints. The Division may also initiate an investigation based on Department of Public Health findings of EMTALA violations, or its review of Low Income Patient application and claims data that either indicates possible diversion of Low Income Patients or demonstrates a significant decrease in the volume of a hospital's Low Income Patient claims.

12.07: Documentation and Audit

(1) Records. Providers must maintain records documenting claims for Eligible Services to Low Income Patients, Emergency Bad Debt services, and Medical Hardship services.

(2) Audits. The Division or its agent may audit Low Income Patient and Emergency Bad Debt claims and/or conduct utilization review, and may adjust claims that are not in compliance with the provisions of 114.6 CMR 12.00.

(a) The Division may adjust claims for services covered by MassHealth, another program of public assistance, or other health insurance plan in which the patient is enrolled.

(b) The Division may adjust claims for services that do not meet the criteria for Eligible Services including Services to Low Income Patients, Emergency Bad Debt services, or Medical Hardship services.

(c) The Division may adjust claims for which the Provider cannot provide documentation required by 114.6 CMR 12.00.

(d) The Division may adjust claims using a methodology to appropriately extrapolate the audit results of a representative sample of accounts.

(e) Processing of Audit Adjustments.

1. Notification. After audit, the Division shall notify the Provider of its proposed audit adjustments. The notification shall be in writing and shall contain a complete listing of all proposed adjustments.
2. Objection Process.
   a. A Provider may file a written objection to a proposed audit adjustment within 15 business days of the mailing of the notification letter.
   b. The written objection must, at a minimum, contain:
      i. Each adjustment to which the Provider is objecting,
      ii. the fiscal year for each disputed adjustment,
      iii. the specific reason for each objection, and

iv. all documentation which supports the Provider's position.

c. Upon review of the Provider's objections, the Division shall notify the Provider of its determination in writing. If the Division disagrees with the Provider's objections, in whole or in part, the Division shall provide the Provider with an explanation of its reasoning.

d. The Provider may request a conference on objections after receiving the Division's explanation of reasons. The Division will schedule such conference on objections if it determines that further articulation of the Provider's position would promote resolution of the disputed adjustments.

12.08: Other Provisions

(1) Provider Responsibilities.

(a) A Provider shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

(b) A Provider or agent thereof shall not seek legal execution against the personal residence or motor vehicle of a patient or Guarantor without the express approval of the Provider's Board of Trustees. All approvals by the Board must be made on an individual case basis.

(c) Credit and Collection Policies.

1. Filing Requirements. Each Provider must file a copy of its Credit and Collection Policy with the Division. The Credit and Collection Policy must conform to the requirements of the regulation.

a. a new Provider must file a copy of its Policy prior to Division approval to submit claims for payments for Eligible Services;

b. within 90 days of adoption of amendments to this regulation that would require a change in the Credit and Collection Policy;

c. when a Provider changes its Credit and Collection Policy;.

d. when two Providers merge and request to be paid as a single merged entity.

2. Content Requirements. A Provider's Credit and Collection Policy must contain:

a. Standard collection policies and procedures

b. Policies and procedures for collecting financial information from patients

c. Emergency Care Classification. A Hospital must provide a detailed policy on its practices for classifying persons presenting themselves for unscheduled treatment, the urgency of treatment associated with each identified classification, the location(s) at which patients might present themselves, and any other relevant and necessary instructions to Hospital personnel that would see these patients. The policy must include the classifications which qualify as Emergency Care and as Urgent Care, as defined in 114.6 CMR 12.02, and other services including "elective" or "scheduled" services.

d. The policy on deposits and payment plans for qualified patients as described in 114.6 CMR 12.08(f).

e. Copies of billing invoices, award or denial letters, and any other documents used to inform patients of the availability of assistance.

(d) Notices.

1. A Provider must provide individual notice of the availability of financial assistance programs to a patient expected to incur charges, exclusive of personal convenience items or services, that may not be paid in full by third party coverage.
2. A Provider or its designee must include a notice about Eligible Services to Low Income Patients and programs of public assistance in its initial bill.
3. A Provider must include a brief notice about Eligible Services to Low Income Patients in all written Collection Actions. The following language is suggested, but not required, to meet the notice requirements of this section: "If you are unable to pay this bill, please call (phone #). Financial assistance is available."
4. A Provider must notify the patient that the Provider offers a payment plan as described in 114.6 CMR 12.08(f), if the patient is determined to be a Low Income Patient pursuant to 114.6 CMR 12.03(3)(b) or qualifies for Medical Hardship.

(e) Signs. Providers must post signs, in the inpatient, clinic, emergency admissions/registration areas and in business office areas that are customarily used by patients, that conspicuously inform patients of the availability of financial assistance programs and the Provider location at which to apply for such programs. Signs must be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices must be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the Provider's service area. Signs must notify patients of the availability of financial assistance and of other programs of public assistance. The following language is suggested, but not required:

1. "Are you unable to pay your hospital bills? Please contact a counselor to assist you with various alternatives." or
2. "Financial assistance is available through this institution. Please contact _____."

(f) Deposits and Payment Plans.

1. A Provider may not require pre-admission and/or pretreatment deposits from individuals that require Emergency Care or that are determined to be Low Income Patients pursuant to 114.6 CMR 12.03(3).
2. A Provider may request a deposit from individuals determined to be Low Income Patients pursuant 114.6 CMR 12.03(3)(d). Such deposits must be limited to 20% of the Deductible amount, up to $500. All remaining balances are subject to the payment plan conditions established in 114.6 CMR 12.08(1)(d).
3. A Provider may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 12.08(2).
4. An individual with a balance of $1,000 or less, after initial deposit, must be offered a one year payment plan with a minimum monthly payment of $25. A patient that has a balance of more than $1,000, after initial deposit, must be offered at least a two year payment plan.

(2) Patient Rights and Responsibilities.

(a) Providers must advise patients of the right to:

1. apply for MassHealth and Low Income Patient determination;
2. a payment plan, as described in 114.6 CMR 12.08(f), if the patient is determined to be a Low Income Patient pursuant to 114.6 CMR 12.03(3)(b) or qualifies for Medical Hardship;
3. a written notice of the eligibility determination; and
4. a written notice of the right to file a grievance.

(b) A Patient that receives Eligible Services must:

1. provide all required documentation;
2. inform MA-21 or the Provider that determined the patient's eligibility status of any changes in Family Income or insurance status; and
3. track the patient Deductible and provide documentation to the Provider that the deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider.

(3) Populations exempt from Collection Action

1. A Provider shall not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, participants in the Healthy Start program, or participants in the CenterCare Program, except that the Provider may bill patients for any co-pays and deductibles required under the program of assistance. The Provider may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Provider shall cease its collection activities.

(b) Participants in the Children's Medical Security Plan whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines are also exempt from Collection Action. The Provider may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Provider shall cease all collection activities.

(c) Low Income Patients determined pursuant to 114.6 CMR 12.03(3)(a) are exempt from Collection Action, except for co-pays and deductibles that are not Eligible Services under 114.6 CMR 12.03(6)(b).

(d) Low Income Patients determined pursuant to 114.6 CMR 12.03(3)(b) are exempt from Collection Action for the portion of his or her Provider bill that exceeds the Deductible, except Collection Actions for co-pays and deductibles that are not Eligible Services under 114.6 CMR 12.03(6)(b).

(e) A Provider may not undertake a Collection Action against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution.

12.09: Administrative Bulletins

The Division may, from time to time, issue Administrative Information Bulletins to clarify the provisions of 114.6 CMR 12.00. In addition, the Division may issue Administrative Information

Bulletins which specify the information and documentation necessary to implement 114.6 CMR 12.00.

12.10: Severability

The provisions of 114.6 CMR 12.00 are hereby declared to be severable. If any such provisions or the application of such provisions shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 12.00.

Regulatory authority: M.G.L. c. 118G

114.6 CMR 12.00: M.G.L. c. 118G